We will have two votes this morning and then we will have that period of morning business. Following some time for a bill introduction, there will be time available for the Senators to express their gratitude.

The next vote, following the two votes which are about to begin, will begin at 12:30, and will be on invoking cloture on the Estrada nomination. Additional votes will occur this afternoon. I will update Members later this morning.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

PARTIAL-BIRTH ABORTION BAN ACT OF 2003

The PRESIDING OFFICER. Under the previous order, the Senate will now resume consideration of S. 3, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 3) to prohibit the procedure commonly known as partial-birth abortion.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I ask unanimous consent to have printed in the RECORD prior to the vote on S. 3, four letters from specialists in maternal fetal medicine in response to the letter the Senator from California had printed in the RECORD yesterday.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ROCKFORD HEALTH SYSTEM, DIVISION OF MATERNAL-FETAL MEDICINE,

Rockford, IL, March 12, 2003.

Hon. RICK SANTORUM,
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: I am writing to contest the letter submitted to Senator Feinstein by Philip D. Darney, MD supporting the ''medical exemption''; to the proposed restriction of the partial birth abortion (or as abortionists call it ''intact D&E'').

I am a diplomate board certified by the American Board of Obstetrics and Gynecology in general Obstetrics and Gynecology and in the sub-specialty of Maternal-Fetal Medicine. I serve as a Visiting Clinical Professor in Obstetrics and Gynecology, University of Illinois at Chicago, Department of Obstetrics and Gynecology, College of Medicine at Rockford, Rockford, Illinois; as an Adjunct Professor of Obstetrics and Gynecology, at Midwestern University, Chicago College of Osteopathic Medicine, Department of Obstetrics and Gynecology; and as an Adjunct Associate Professor of Obstetrics and Gynecology Uniformed Services University of Health Sciences, F. Edward Herbert School of Medicine, Washington, D.C. I have authored over 50 peer review articles in the obstetrics and gynecologic literature, presented over 100 scientific papers, and have participated in over 40 research projects,

In my over 14 years as a Maternal-Fetal Medicine specialist I have never used or needed the partial birth abortion technique to care for my complicated or life threatening conditions that require the termination of pregnancy. Babies may need to be delivered early and die from prematurity, but there is never a medical need to perform this heinous act.

I have reviewed both cases presented by Dr. Darney, and quite frankly, do not understand why he was performing the abortions he indicates, yet alone the procedure he is using. If the young 25 year old woman has a placenta previa with a clotting disorder, the safest thing to do would be to place her in the hospital, transfuse her to a reasonable hematocrit, adjust her clotting parameters, watch her closely at bed rest, and deliver a live baby. If the patient had a placenta previa, pushing laminaria (sterile sea weed) up into her cervix, and potentially through the previa, is contraindicated. It is no surprise to anyone that the patient went, from stable without bleeding, to heavy bleeding as they forcibly dilated her cervix to 3 centimeters with laminaria. The use of the dangerous procedure of blinding pushing scissors into the baby's skull (as part of the partial birth abortion) with significant bleeding from a previa just appears reckless and totally unnecessary.

Regarding the second case of the 38 year old woman with three cesarean sections with a possible accreta and the risk of massive hemorrhage and hysterectomy due to a placenta previa, it seems puzzling why the physician would recommend doing an abortion with a possible accreta as the indication. Many times, a placenta previa at 22 weeks will move away from the cervix so that there is no placenta previa present and no risk for accreta as the placenta moves away from the old cesarean scar. (virtually 99.5% of time this is the case with early previas). Why the physicians did not simply take the woman to term, do a repeat cesarean section with preparations as noted for a possible hysterectomy, remains a conundrum. Dr. Darney actually increased the woman's risk for bleeding, with a horrible outcome, by tearing through a placenta previa, pulling the baby down, blindly instrumenting the baby's skull, placing the lower uterine segment at risk, and then scraping a metal instrument over an area of placenta accreta. No one I know would do such a foolish procedure in the mistaken belief they would prevent an accreta with a D&E.

Therefore, neither of these cases presented convincing arguments that the partial birth abortion procedure has any legitimate role in the practice of maternal-fetal medicine or obstetrics and gynecology. Rather, they demonstrate how cavalierly abortion practices are used to treat women instead of the second medical practices that result in a live baby and an unharmed mother.

Sincerely,

BYRON C. CALHOUN, MD.

MARCH 13, 2003.

Hon. RICK SANTORUM,
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: I have reviewed the letter from Dr. Darney describing two examples of what he believes are high risk pregnancy cases that show the need for an additional ''medical exemption'' for partial birth abortion (also referred to as intact D&E). I am a specialist in maternal-fetal medicine with 23 years of experience in obstetrics. I teach and do research at the University of Minnesota. I am also co-chair of the Program in Human Rights in Medicine at the University. My opinion in this matter is my own.

In the rare circumstances when continuation of pregnancy is life-threatening to a mother I will end the pregnancy. If the fetus is viable (greater than 23 weeks) I will recommend a delivery method that will maximize the chance for survival of the infant, explaining all of the maternal implications of such a course. If an emergent life-threatening situation requires emptying the uterus before fetal viability then I will utilize a medically appropriate method of delivery, including intact D&E.

Though they are certainly complicated, the two cases described by Dr. Darney describe situations that were not initially emergent. This is demonstrated by the use of measures such as dilation of the cervix that required a significant period of time. In addition, the attempt to dilate the cervix with placenta previa and placenta accreta is itself risky and can lead to life-threatening hemorrhage. There may be extenuating circumstances in Dr. Darney's patients but most obstetrical physicians would not attempt dilation of the cervix in the presence of these complications. It is my understanding that the proposed partial birth abortion ban already has an exemption for situations that are a threat to the life of the mother. This would certainly allow all measures to be taken if heavy bleeding, infection, or severe preeclampsia required evacuation of the uterus.

The argument for an additional medical exemption is redundant; furthermore, its inclusion in the legislation would make the ban virtually meaningless. Most physicians and citizens recognize that in rare life-threatening situations this gruesome procedure might be necessary. But it is certainly not a procedure that should be used to accomplish abortion in any other situation.

Passage of a ban on partial birth abortion with an exemption only for life-threatening situations is reasonable and just. It is in keeping with long-standing codes of medical ethics and it is also in keeping with the provision of excellent medical care to pregnant women and their unborn children.

Sincerely,

STEVE CALVIN, MD.

REDMOND, WA,
March 12, 2003.

Hon. RICK SANTORUM:
U.S. Senate Office Building,
Washington, DC.

DEAR SENATOR SANTORUM: The purpose of this letter is to counter the letter of Dr. Philip Darney, M.D. to Senator Diane Feinstein and to refute claims of a need for an exemption based on the health of the mother in the bill to restrict ''partial birth abortion.''

I am board certified in Maternal-Fetal Medicine as well as Obstetrics and Gynecology and have over 20 years of experience, 17 of which have been in maternal-fetal medicine. Those of us in maternal-fetal medicine are asked to provide care for complicated, high-risk pregnancies and often take care of women with medical complications and/or fetal abnormalities.

The procedure under discussion (D&X, or intact dilation and extraction) is similar to a destructive vaginal delivery. Historically such were performed due to the risk of caesarean delivery (also called hysterotomy) prior to the availability of safe anesthetic, antiseptic and antibiotic measures and frequently on a presumably dead baby. Modern medicine has progressed and now provides better medical and surgical options for the obstetrical patient.

The presence of placenta previa (placenta covering the opening of the cervix) in the two cases cited by Dr. Darney placed those mothers at extremely high risk for catastrophic life-threatening hemorrhage with any attempt at vaginal delivery. Bleeding from placenta previa is primarily maternal, not fetal. The physicians are lucky that their interventions in both these cases resulted in living healthy women. I do not